VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 22, 2014

Mr. Robert Simpson, Administrator
Brattleboro Retreat
Anna Marsh Lane PO Box 803
Brattleboro, VT 05301-0803

Provider ID:474001

Dear Mr. Simpson:

A complaint investigation was completed at your facility on **August 18, 2014**. Based upon the investigations findings, Brattleboro Retreat was found to be out of compliance with the Conditions of Participation for Patient Rights (482.13) and QAPI (482.21), as well as two standard level requirements.

This letter serves to notify you of Brattleboro Retreat's failure to comply with the Conditions of Participation as stated above. This investigation will fall under the same termination date of October 6, 2014, as stated in the letter dated July 8, 2014, sent to you by the Centers for Medicare and Medicaid Services (CMS).

Please submit a plan of correction for all deficiencies by **September 1, 2014**. A revisit will occur.

If you have any questions concerning this letter, please contact me at (802) 871-3317.

Sincerely,

Frances L Keeler

Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474001	A. BUILDING _____ B. WING _____	C 08/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection under State Agency jurisdiction on 8/11/14 through 8/13/14 and completed on 8/18/14. to determine compliance with Condition of Participation for: Patient Rights; Nursing Services, Quality Assurances/Performances Improvement for Complaint # 12127. The following regulatory violations were identified: Based on information gathered, the hospital was determined not to be in compliance with Conditions of Participation for: Patient Rights and Quality Assessment/Performance Improvement.	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interview and record reviews conducted on days of survey, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to provide sufficient interventions to assure each patient's rights are protected by maintaining care in a safe setting. Findings include: Refer to Tag: A- 144	A 115		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	A 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 144	Continued From page 1 hospital failed to provide sufficient interventions to assure each patient's rights are protected by maintaining care in a safe setting. Findings include: On 7/16/14 Patient #1, with a diagnosis of Anxiety, Assaultive behaviors, PTSD and Suicidal ideation was admitted to the Tyler 3/Adolescent unit. Over the past 2 years Patient #1 had 2 prior hospitalizations and had resided in residential treatment programs for sexual offending and aggressive behaviors and self-harming behaviors. The initial physician admission assessment states Patient #1 was not only a victim of sexual abuse but also a "...perpetrator against males, females and mother." A Social Work Progress note for 7/17/14 states within "Symptoms observed/Assessment Summary:..... Patient has a history with many flags in it which bear watching most obviously sexualized actions with both males and females". In addition, the initial Social Service Assessment completed on 7/17/14 remarks: " Past/present Functioning: ...s/he has a history of sexualized behavior and can become infatuated with female staff. " The Interdisciplinary Treatment Plan for 7/17/14 identified Patient #1 to have Impulsive Behavior manifested by a "History of sexualized behaviors toward others" however goals and treatment modalities did not address how they would assure Patient #1 maintained personal and physical boundaries with both staff and other patients. Upon admission it was determined Patient #1 would be on routine 15 minute safety checks. On 7/18/14, Patient #1 was also assigned to the Community Area (a location near the nurses station which enable staff to monitor patients at all times during daily activities). While assigned	A 144		

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A 144	Continued From page 2 to the Community Area Patient #1 developed a relationship with an older peer, Patient #2, who was admitted for depression and has a history of being sexually, physically and emotionally abused. Patient #2's room was in close proximity to the Community Area allowing Patient #1 to sit outside or across from Patient #2's room while monitored by Tyler 3 staff. Multiple conversations transpired between Patient #1 and #2 during which time both patients declined to take part in any of the scheduled activities and support groups. On 7/23/14 during an onsite visit to Tyler 3, staff from a residential program who were evaluating Patient #1's potential to return to their program upon discharge voiced concern to a Tyler 3 Social Worker of Patient #1's interaction with Patient #2 given the past history of inappropriate attachment with older peers and staff. On 7/24/14 a Nursing progress note at 3:35 PM states a patient informed staff that "a couple of days ago" Patient #1 had inappropriate sexual contact with Patient #2. When approached by both nursing staff and physicians, both Patient #1 and #2 denied sexual contact had occurred. Nursing progress note for 7/25/14 at 2:41 PM states Patient #2 reported to both RN and Clinical Manager that "a couple of days ago" Patient #1 had placed fingers in her vagina. A Physician Progress note for 7/28/14 states Patient #1 admitted to engaging in sexual activity with Patient #2. Once made aware of the events reported, Patient #1 was placed in ALSA (Low Stimulation Area) and on 1:1 monitoring. A Physician Progress note for 8/1/14 states Patient #1 "..has a significant history of sexual offending behaviors which require high level of supervision".	A 144		

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A 144	Continued From page 3 Per interview on 8/12/14 at 5 PM, the Social Worker assigned to the Treatment Team for Patient #1 confirmed although reports were made to the required State authorities and/or guardians regarding the inappropriate sexual contact, s/he was unable to provide an explanation how the event could have occurred when Tyler 3 staff were assigned to monitor Patient #1 and his/her movements/activities throughout the unit. ". Per interview on 8/13/14 at 4:30 PM, the Treatment team (Psychiatrists, Social Worker and Clinical Nurse Manager) were unable to provide any further explanation how adolescent patients requiring psychiatric hospitalization were not provided an environment that protects their vulnerability and ensures the care they require is in a safe setting. In addition, it was also acknowledged the treatment plan for Patient #1 failed to specifically address individualized actions/interventions to assist staff in the prevention of inappropriate sexual behaviors from occurring during the hospitalization of Patient #1 to ensure the safety of all patients on Tyler 3.	A 144		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention	A 263		

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A 263	Continued From page 4 and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation for Quality Assessment and Performance Improvement (QA/PI) was not met due to the hospital's failure to assure that all staff utilized the established Incident/Occurrence reporting system to identify a potential adverse event and opportunity for improvement; and failed to fully analyze, develop and implement actions and mechanisms for learning throughout the hospital, following an identified adverse event. Findings include: Refer to Tag: 286 This is a repeat citation.	A 263		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.	A 286		

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A 286	Continued From page 5 (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure that all staff utilized the established Incident/Occurrence reporting system to identify a potential adverse event and opportunity for improvement; and failed to fully analyze, develop and implement actions and mechanisms for learning throughout the hospital, following an identified adverse event. Findings include: On 7/16/14 Patient #1, with a diagnosis of Anxiety, Assaultive behaviors, PTSD and Suicidal ideation was admitted to the Tyler 3/Adolescent unit. Over the past 2 years Patient #1 had 2 prior hospitalizations and had resided in residential treatment programs for sexual offending and aggressive behaviors and self-harming behaviors. The initial physician admission assessment states Patient #1 was not only a victim of sexual abuse but also a "...perpetrator against males, females and mother." A Social Work Progress note for 7/17/14 states within "Symptoms observed/Assessment Summary:..... Patient has a history with many flags in it which bear watching most obviously sexualized actions with both males and females". In addition, the initial Social	A 286		

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A 286	Continued From page 6 Service Assessment completed on 7/17/14 remarks: " Past/present Functioning: ...s/he has a history of sexualized behavior and can become infatuated with female staff. " The Interdisciplinary Treatment Plan for 7/17/14 identified Patient #1 to have Impulsive Behavior manifested by a "History of sexualized behaviors toward others" however goals and treatment modalities did not address how they would assure Patient #1 maintained personal and physical boundaries with both staff and other patients. Upon admission it was determined Patient #1 would be on routine 15 minute safety checks. On 7/18/14, Patient #1 was also assigned to the Community Area (a location near the nurses station which enable staff to monitor patients at all times during daily activities). While assigned to the Community area Patient #1 developed a relationship with an older peer, Patient #2, who was admitted for depression and has a history of being sexually, physically and emotionally abused. Patient #2's room was in close proximity to the Community Area allowing Patient #1 to sit outside or across from Patient #2's room while monitored by Tyler 3 staff. Multiple conversations transpired between Patient #1 and #2 during which time both patients declined to take part in any of the scheduled activities and support groups. On 7/23/14 during an onsite visit to Tyler 3, staff from a residential program who were evaluating Patient #1's potential to return to their program upon discharge voiced concern to a Tyler 3 Social Worker of Patient #1's interaction with Patient #2 given the past history of inappropriate attachment with older peers and staff. On 7/24/14 a Nursing progress note at 3:35 PM states a patient	A 286		

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A 286	Continued From page 7 informed staff that "a couple of days ago" Patient #1 had inappropriate sexual contact with Patient #2. When approached by both nursing staff and physicians, both Patient #1 and #2 denied sexual contact had occurred. Nursing progress note for 7/25/14 at 2:41 PM states Patient #2 reported to both RN and Clinical Manager that "a couple of days ago" Patient #1 had placed fingers in her vagina. A Physician Progress note for 7/28/14 states Patient #1 admitted to engaging in sexual activity with Patient #2. Once made aware of the events reported, Patient #1 was placed in ALSA (Low Stimulation Area) and on 1:1 monitoring. A Physician Progress note for 8/1/14 states Patient #1 "..has a significant history of sexual offending behaviors which require high level of supervision". Per interview on 8/12/14 at 5 PM, the Social Worker assigned to the Treatment team for Patient #1 confirmed although reports were made to the required State authorities regarding the inappropriate sexual contact, s/he was unable to provide an explanation how the event could have occurred when Tyler 3 staff were assigned to monitor Patient #1 and his/her movements/activities throughout the unit. At the time of interview the Manager of Performance Improvement and Risk Management confirmed s/he had not been made aware of the events involving Patient #1 and #2 and further confirmed an Incidence/Occurrence Report had not been completed. Although evidence was provided that an Internal Investigation was conducted by the Clinical Nurse Manager on 7/25/14, the opportunity to further analyze the event to identify causes and identify opportunities for further improvement did not occur.	A 286		